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IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

ROCKFORD MEMORIAL CORPORATION and
SWEDISHAMERICAN CORPORATION,
Petitioners,

v.

UNITED STATES OF AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF OF VOLUNTARY HOSPITALS OF AMERICA, INC. AS AMICUS CURIAE SUPPORTING PETITIONERS

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BRIEF OF VOLUNTARY HOSPITALS OF AMERICA, INC. AS AMICUS CURIAE SUPPORTING PETITIONERS

STATEMENT OF INTEREST

The Voluntary Hospitals of America, Inc. ("VHA"), as amicus curiae, submits this brief in support of the petition for a writ of certiorari in the above captioned case.[1] VHA is the nation's largest alliance of not-for-profit community-based voluntary hospitals, comprising over 650 hospitals and representing approximately 20% of the hospital beds in the United States.

Recent hospital economic trends evidence both a decline in inpatient admissions and a decline in the length of hospital stay per case, creating substantial overcapacity and resulting in an unparalleled number of hospital closures and consolidations. In many instances, mergers and consolidations between not-for-profit health care institutions in the same community represent the most promising way of avoiding the loss of access to medical services resulting from hospital closures.[2] VHA's not-for-profit hospital members are, therefore interested in the applicability of the antitrust laws to mergers between not-for-profit organizations.

At bottom, the government's argument in this case, endorsed by both the district court and the court of appeals, is that mergers of private not-for-profit hospitals may be invalidated merely because they result in market concentration statistics in excess of the government's generally applicable concentration standards. Yet the un-

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[1] This brief is submitted with the consent of all parties, in accordance with Sup. Ct. R. 37.2. The written consents have been filed with the Clerk of the Court.

[2] *See, e.g.*, Dyer, *Hospitals Saw Patient Margin Vanish in 1988*, Hospitals, May 5, 1989, at 56; Burda, *Why Hospitals Close*, Mod. Healthcare, Mar. 24, 1989, at 24; Bell, *U.S. Should Face Facts on Mergers*, Mod. Healthcare, Feb. 3, 1989, at 26; Greene, *Consolidation Continues Among Nation's Hospitals*, Mod. Healthcare, Apr. 15, 1988, at 4; Cherskov, *What's Driving Upcoming Mergers?*, Hospitals, Jan. 5, 1987, at 36.

critical application of these market concentration standards is likely to invalidate most mergers of not-for-profit hospitals in this country.[3] It has been estimated that (using the government's market definition criteria) a merger of any two or more hospital facilities would violate the market concentration standards contained in the Justice Department's Merger Guidelines in 84% of the communities in this country which have more than one hospital.[4] *See* Kopit & McCann, *The Justice Department's Non-Profit Hospital Merger Policy: Forcing a Square Peg into a Round Hole, reprinted in* 3 Antitrust Health Care Chronicle, No. 4, at 3 (ABA Meeting in Honolulu, Haw. Aug. 6-9, 1989).

Even in concentrated markets, mergers of not-for-profit hospitals can have salutary results. Such mergers can reduce unnecessary duplication and costs, thereby significantly improving hospital efficiency. Of course, mergers between not-for-profit hospitals are not always pro-competitive, nor should such mergers be exempt from antitrust scrutiny. Where anti-competitive mergers take place they should be challenged and invalidated. In each case, the decision must be made on the basis of available evidence, not on the basis of strongly held, but empircally insupportable, beliefs.

Unless the appropriate standards of analysis are articulated by this Court, both not-for-profit hospitals seeking

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[3] Thus, if the government's argument is permitted to stand the result will be fewer mergers and more failures. This result is hardly beneficial to consumers. Of course, if one of the hospitals is "failing," a merger might be permissible under the antitrust laws. But at that point, it is not clear that a merger can be accomplished.

[4] FTC, *Statement of Federal Trade Commission Concerning Horizontal Mergers* (June 14, 1982), *reprinted in* 2 Trade Reg. Rep. (CCH) ¶ 4516 (1982), does not explicitly rely on stated market concentration levels to trigger an investigation. However, in challenges to hospital mergers under the Clayton Act, the FTC has relied heavily upon market concentration statistics. *Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

to merge, and hospitals considering complaints to the government regarding these mergers, will be assessing their actions by the wrong standards, or even worse, acting in the absence of any authorative guidance at all. Because the circuit court's analysis in this case fails to explore either the unique aspects of the hospital market or the incentives that control the behavior of not-for-profit entities operating within that market, an erroneous and misleading signal has been sent to both hospitals and consumers, as well as to the courts that will be required to address subsequent hospital merger cases. The adverse public policy consequences of continued confusion in this critical area are both too obvious to mistake, and too serious to disregard.

REASONS FOR GRANTING THE PETITION FOR A WRIT OF CERTIORARI

This Court should grant a writ of certiorari in order to ensure that correct guidance is given to not-for-profit hospitals considering consolidations, and that appropriate standards are utilized in distinguishing those mergers which are beneficial to consumers from those which are harmful.

ARGUMENT

I. COMPETITION IN THE HOSPITAL MARKET DOES NOT FOLLOW THE COMPETITIVE PARADIGM

Despite the attention given to the alleged emergence of "competition" in health care, largely a result of health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"), which may select hospitals based, in part, on price, there are still significant differences between hospital markets and the competitive paradigm. Indeed, to say that hospitals operate in anything approximating a "free market" misses the point. Thus, existing hospital capacity was, in large part, developed as a result of the federal Hill-Burton program which funded the building of hospitals, and of the reim-

bursement policies of the Medicare program which, until 1983, financed hospitals' services on the basis of their costs. Similarly, there can be little doubt that the recently enacted Prospective Payment System ("PPS")—which changed the basis of Medicare payment for services to a fixed price per admission—has been a major factor in forcing a reduction in duplication of services, and the consequent increase in over-capacity.[5] Thus, the number of hospitals in any market today has far more to do with federal policy than with the operation of market forces.

A. The Trend Toward Closures and Consolidations Is Fostered by Federal Payment Policies

Most hospitals in this country are not-for-profit charitable institutions, and it cannot be disputed that the trend among these hospitals is toward closure or consolidation.[6] Annual survey data from the American Hospital Association ("AHA") shows that closures increased steadily between 1982, when only 23 hospitals ceased operation, and 1988, when a record number of 81 hospitals closed.[7] Moreover, between 1982 and 1986, 79 hospital mergers occurred, 50 of which took place between 1984

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[5] Curiously, the Medicare program continues to reimburse hospitals on a cost basis for their capital costs. Thus, to the extent that the existence of excess capacity creates higher costs, the government actually pays more.

[6] There are currently 3,242 not-for-profit hospitals, compared with 790 for-profit hospitals. In addition, there are 1,501 state and local government hospitals and 342 federal government hospitals. AHA, *Hospital Statistics* 20 (1989-90 ed.)

[7] *See* Burda, *Record 81 Hospitals Close*, Mod. Healthcare, Jan. 20, 1989, at 4; Burda, *Hospital Closures Top Record at 79*, Mod. Healthcare, Mar. 25, 1988, at 4. A recent survey of 1,419 hospital officials found that 48% believe that their institutions are vulnerable to financial failure in the next five years. For hospitals with fewer than 100 beds, 63% said they are at risk of closing. *Rising Numbers of Hospitals Forced to Close*, N.Y. Times, June 23, 1988, at A17.

and 1986.[8] Recent estimates indicate that by the year 2000 approximately 20% of the current acute care bed capacity will be closed.[9]

The reasons for this trend are well known. The utilization of hospital services has declined dramatically over the last several years.[10] Inpatient hospital admissions fell .5% in 1983, 4% in 1984, 4.6% in 1985, 2.1% in 1986, .6% in 1988, and .7% in 1988. In total, over four million fewer people were admitted to hospitals in 1988 than were admitted in 1982. Concurrent with these reductions in admissions, inpatient lengths of stay have declined. The net result of these trends is the creation of substantial overcapacity: fewer patients are staying fewer days than in the first part of the 1980's.

The change in the federal Medicare payment system implemented in 1984 has been a significant contributor to the statistical trends affecting hospitals. At that time, Medicare, which accounts for approximately 40% of the average hospital's revenue, ceased its system of cost reimbursement of most hospital services. PPS pays hospitals a predetermined sum for each Medicare patient based on that patient's specific diagnosis. If the cost of treating the patient exceeds the amount paid by Medicare, the hospital (except in rare "outlier" cases) must absorb the difference regardless of the hospital's charge structure. Moreover, the federal government has announced that it does not intend to increase Medicare payments in proportion to increases in nursing costs and other costs incurred in hospitals.[11] Indeed, the former

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[8] *AHA Annual Survey of Hospitals* (1983-1987) (unpublished tabulations).

[9] *Fewer Hospital Beds Predicted by Year 2000,* AHA News, June 20, 1988, at 3.

[10] The utilization and economic data which follow are from annual data compiled by AHA. These data are published each year in the May 5 issue of *Hospitals* magazine.

[11] The trend has already led to a steady decline in hospital revenue margins. Since 1984, total net revenue margins have declined 24%

deputy director of the Medicare program was quoted as stating that because of Medicare payment constraints, hospital margins may be "close to zero," but that "we could do just fine with fewer hospitals. The question is whether the right hospitals will go out of business." [12]

B. Mergers of Not-For-Profit Hospitals Must Be Viewed in an Appropriate Context

Largely as a result of health insurance, price sensitivity typically is not an important element in the purchase of hospital services for the bulk of the population.[13] Moreover, the Medicare PPS payment program, described above, is simply a substituted form of regulation. There is no pretense of market pricing under PPS.[14]

The different economic behavior of individual not-for-profit hospitals suggests an even more important reason for viewing mergers of such hospitals as distinct from mergers of most commercial institutions. Indeed, the

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and net patient revenue margins have declined 95% in the same period. In 1987, the average hospital earned just one dollar of surplus on each $1,000 of patient revenue. By 1988, aggregate patient revenue margins fell to zero.

[12] New York Times, *supra.*

[13] Health insurance diminishes the impact of price differences for a simple reason—consumers are not significantly affected by changes in hospital charges. Some prepaid medical plans, e.g., HMOs and PPOs, may represent an exception to the general rule, but in many areas HMO and PPO market penetration is low, although typically increasing. Moreover, larger discounts to HMOs may simply mean higher prices for others given hospitals' need to cost shift. Inguanzo, *Are Consumers Sensitive to Hospital Costs?*, Hospitals, Feb. 1, 1985, at 68; *see also* Feldstein, *Health Care Econ.* 93-101 (1983) (and research cited therein); *United States v. North Dakota Hosp. Ass'n,* 640 F. Supp. 1028 (D.N.D. 1986).

[14] Thus, for most not-for-profit hospitals, almost half of their revenues come from governmental payers which set "prices" outside of any market mechanism. A large number of hospitals also are subject to constraints imposed by other large buyers, and to mandatory or voluntary rate review at the state level.

standard presumption that firms in less concentrated markets will offer lower prices or higher quality is based on the assumption that firms seek to maximize profits or surplus. Yet, this assumption is empirically inappropriate for not-for-profit hospitals in many communities across the country.

Researchers have attributed numerous goals other than profit maximization to these institutions. These goals include maximization of output, maximization of quality, maximization of charity care, maximization of community well-being, and maximization of doctors' incomes.[15] While none of these goals is universally recognized as the sole motive for not-for-profit hospitals, research in health economics is seldom based on the assumption that not-for-profit hospitals primarily seek to maximize hospital prices, or profits.

The price-setting decisions of most not-for-profit hospitals reflect this point.[16] Unlike for-profit organizations, not-for-profit hospitals traditionally have set prices according to their financial requirements rather than their perceptions of market-clearing prices. Indeed, published research demonstrates that charges at not-for-profit hospitals, on average, are less than charges for similar services at comparable for-profit hospitals. These differences appear to reflect differences in pricing strategy, rather than simple differences in underlying costs.[17] Thus, in the words of one study,

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[15] Robinson & Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 J.A.M.A. 3241, 3244 (1987); Institute of Medicine, *For-Profit Enterprise in Health Care* (*"IOM Study"*) 21-23 (1986); Feldstein, *supra*, at 213-23.

[16] Of course, not all not-for-profit hospitals behave this way. In each case, the actual behavior is a question of fact to be determined on the evidence in the record. Nevertheless, empirical research demonstrates that there is no support for a blanket presumption that not-for-profit hospitals behave like commercial entities.

[17] Watt, Derzon, Renn, Schramm, Hahn & Pillari, *The Comparative Economic Performance of Investor-Owned Chain and Not-For-*

> [p]roprietary hospitals, whether new or old affiliates in a chain, were ten percent more costly per adjusted patient-day than independent voluntary hospitals—and were more expensive than hospitals in voluntary or public chains,—with either old or new affiliations.

R. Hollingsworth & E. Hollingsworth, Institution for Social and Policy Studies, Yale University, *A Comparison of Non-Profit, For-Profit and Public Hospitals in the United States 1935 to the Present* (June 1986).

C. The Circuit Court's Analysis Failed to Consider the Unique Features of the Hospital Market

The circuit court's opinion pays lip service to the principle that anti-competitive effects must be established in the context of the particular market being examined.

> It is regrettable that antitrust cases are decided on the basis of theoretical guesses as to what particular market-structure characteristics portend for competition . . . . We would like to see more effort put into studying the actual effect of concentration on price in the hospital industry as in other industries. If the government is right in these cases, then, other things being equal, hospital prices should be higher in markets with fewer hospitals. This is a studiable hypothesis, by modern methods of multivariate statistical analysis, and some studies have been conducted correlating prices and concentration in the hospital industry. Kopit & McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 Journal of Health Politics, Policy

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Profit Hospitals, 314 New Eng. J. Med. 89 (1986); *IOM Study, supra*, at 80-85; Coelen, *Hospital Ownership and Comparative Costs, reprinted in IOM Study, supra*, at 328-29; Watt, et al., *The Effects of Ownership and Multi-Hospital System Membership on Hospital Functional Strategies and Economic Performance, in IOM Study, supra*, at 277-80; Eskoz, et al., *The Relationship of Hospital Ownership and Service Composition to Hospital Services*, 6 Health Care Financing Rev. 51 (1985); Lewin, Derzon, & Margulies, *Investor-Owneds and Nonprofits Differ in Economic Performance*, Hospitals, July 1, 1981, at 52.

& Law 635, 645-46 and n.30 (1988) (discussing studies).

Pet. App. B at b42-b43.

Nevertheless, the Court went on to dismiss the significance of these studies by stating that "this literature is at an early and inconclusive stage." *Id.* That assertion is simply wrong. In reality, the data is overwhelming that higher market concentration among not-for-profit hospitals does not typically result in higher prices to consumers.[18]

Only six days after the opinion of the circuit court was issued, Health Care Investment Analysts, Inc. released a report entitled, *Competitive Hospital Markets: Differences in Costs and Charges* (Apr. 9, 1990), taken from a data base which included approximately 6,000 hospitals throughout the United States. The study concluded that "[c]harges per case were 24 percent higher in the most competitive markets (four or more hospitals) when compared with the least competitive (one-hospital) and 14 percent higher when compared with hospitals located in moderately competitive markets (two-and-three hospital markets)." App. A, *infra*, at 5a. Similarly, on June 6, 1990, the Wall Street Journal ran a front page article by Ron Winslow entitled, *Competitive Anomaly: Consumers Pay More in 2-Hospital Towns.* That article stated that "[i]n general, hospital costs in two-hospital towns . . . [were] 30% higher than in one-hospital communities, according to a survey by Booz-Allen & Hamilton, Chicago consultants." App. B, *infra*, at 7a. Indeed, substantial evidence to the same effect was introduced by the defendants' economic expert, David M. Eisenstadt,

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[18] While the definitive causes of this phenomenon are not known, it is probable that the existence of insurance plays a significant role. That is, neither physicians nor their patients typically make choices among hospitals based primarily on price. Thus, hospitals compete for physicians—and their patients—based on facilities, amenities, and services, driving costs and prices up. In addition, it is entirely plausible to assume that not-for-profit hospitals are less likely to exercise market power, even where it may exist.

Ph.D., in *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989). Dr. Eisenstadt testified that four separate studies which he conducted involving not-for-profit hospitals, demonstrated no correlation between more concentrated markets and higher hospital prices. App. C, *infra*, at 17a-23a. These studies merely confirm a number of other studies contained in the publication cited by the circuit court.[19]

For many patients, e.g., government patients such as Medicare and Medicaid beneficiaries, hospitals have no market power at all, regardless of the degree of market concentration.[20] Hospital charges, or prices, are irrelevant to government patients, and to the government. Regardless of those charges, the hospital receives no more than the fixed amount which the government pays for each diagnosis. With regard to certain other patients, e.g., indemnity insurance patients, all hospitals have a measure of market power regardless of market concen-

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[19] *See also* Robinson & Luft, *Competition and the Cost of Hospital Care, 1972 to 1982, supra*; Robinson & Luft, *Competition, Regulation, and Hospital Costs, 1982 to 1986*, 260 J.A.M.A. 2676 (1988); Melnick & Zwanziger, *Hospital Behavior Under Competition and Cost-Containment Policies: The California Experience, 1980 to 1985*, 260 J.A.M.A. 2660 (1988). The later work of Robinson and Luft indicates that the relationship may be reversed in unconcentrated markets. That is, in markets with more than 10 hospitals, increases in market concentration may lead to higher costs, if not prices. Of course, most markets have less than 10 hospitals, and mergers in unconcentrated markets are unlikely to prompt challenges in any event.

[20] Virtually every hospital accepts Medicare beneficiaries. Many not-for-profit hospitals have received federal assistance through the Hill-Burton program, and all such hospitals are required, by law, to provide care to Medicare and Medicaid beneficiaries in perpetuity. *American Hospital Ass'n v. Schweiker*, 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984). Moreover, as a practical matter, no hospital can refuse to provide care to Medicare beneficiaries. The volume of revenues provided by the Medicare program, which is by far the largest single payor for most hospitals, is simply too great for any hospital to ignore.

tration because increases in prices or charges by the hospital are not likely to result in shifts of patients to other hospitals. Thus, the critical question that must be asked in any hospital merger case is not whether the hospital has market power, but whether the merger increases defendants' market power and, if so, whether that increased market power is more likely to be used to the detriment of consumers. If the answer to either of those questions is no, the merger should not be held to violate the antitrust laws.[21] Unfortunately, neither the district court nor the circuit court addressed these questions.

Rather than providing any detailed discussion of the possible workings of not-for-profit hospitals, the court of appeals simply dismissed evidence of possible differences in motivations and behavior by labelling those differences "will-o'-the-wisps," and indicating that the district court was free to disregard them, which it did. Pet. App. B at b44. However, the district court's dismissal of the defendants' evidence was itself based on an earlier decision of the circuit court in which the same Judge Posner, who authored the circuit court's opinion in this case, in conclusory terms, asserted that " 'nonprofit form does not change human nature.' " Pet. App. A at a172 (citation omitted). While that may be true, it is equally true that incentives can, and do, change human behavior.

This point has been recognized by one of the Department of Justice's own economists who stated in a published paper that "[a]nalyses which ignore [a] firm['s] organizational and financial structure are incomplete inso much as these factors are crucial to the incentives and costs confronted by the decision maker." J. Joyce, Economic Analysis Group, Antitrust Division, U.S. Dep't of Justice, *The Effect of Firm Organizational Structure on Price Fixing Deterrents* (1986).

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[21] Indeed, the Department of Justice's 1984 Merger Guidelines are based on the premise that "mergers should not be permitted *to create or enhance 'market power' or to facilitate its exercise.*" 49 Fed. Reg. 29,827 (1984) (emphasis added).

The available data supports the contention that incentives affect behavior. Thus, recent studies conclude that not-for-profit hospitals devote substantially more of their resources to uncompensated care.[22] Lewin, Eckels & Miller, *The Provision of Uncompensated Care By Not-For-Profit Hospitals*, 318 New Eng. J. Med. 1212 (1988); Relman, *Are Voluntary Hospitals Caring for the Poor?*, 318 New Eng. J. Med. 1198 (1988).

Thus, at the extreme, most people would recognize that a religious hospital run by the Sisters of Mercy or the Daughters of Charity is unlikely to have precisely the same operational philosophy as a for-profit hospital controlled by a group of Ivan Boesky wannabees, accountable to their shareholders or themselves. Clearly, the economic and non-economic incentives imposed on not-for-profit hospitals can be different in many cases from the incentives imposed on for-profit hospitals. Any adequate analysis of actual and/or likely effects of a merger between not-for-profit hospitals must consider possible differences and take them into account. Reliance on labels, or asserted platitudes about human nature, simply will not suffice.

Significantly, administrators in not-for-profit hospitals are not likely to be rewarded for increasing price or profits. Moreover, members of the Board of Trustees, by definition, cannot benefit from their ownership in stock of the corporation. Indeed, the Trustees in most not-for-profit hospitals are likely to be, as they were in *Rockford*, members of the business community whose companies pay the tab for increased hospital costs. Such people have no incentive to permit their hospitals to raise prices unnecessarily. Instead, they have every incentive to keep prices as low as possible. With these organizational characteristics, antitrust violations based on an exercise of

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[22] Although not-for-profit hospitals devote a disproportionate amount of resources to uncompensated care, compared to for-profit hospitals, they nevertheless have lower charges and costs. Lewin, Derzon & Margulies, *supra*, at 52-58.

market power are less likely to occur in not-for-profit situations than they are in purely commercial contexts. "Antitrust violations are perpetrated by individuals that personally gain from committing them. They are likely to have [some] ownership interests in the firms with which they are associated." J. Joyce, *supra*, at 20-21. This conclusion is particularly important where, as here, the applicable legal standard—Section 1 of the Sherman Act—does not permit a finding of liability under circumstances where such liability could be imposed under Section 7 of the Clayton Act.

II. SECTION 7 OF THE CLAYTON ACT DOES NOT REACH AFFILIATIONS BETWEEN NOT-FOR-PROFIT CHARITABLE HOSPITALS

Although the circuit court concluded that Section 7 of the Clayton Act, 15 U.S.C. § 18, is inapplicable to the petitioners' affiliation, it went on to assert that the government's problem was simply that it made the wrong argument. Pet. App. B at b14. According to the circuit court, the Federal Trade Commission ("FTC") does have jurisdiction over not-for-profit hospital mergers under Section 7 through the application of Section 11 of the Clayton Act, 15 U.S.C. § 21. Thus, the teaching of the circuit court's analysis is that Section 7 of the Clayton Act will apply to other mergers of not-for-profit hospitals.

Essentially, the circuit court adopted the analysis of a recent FTC ruling which indicated that the FTC believes it has Clayton Act jurisdiction over asset acquisitions (and presumably mergers) of not-for-profit hospitals, as a result of Section 11 of the Clayton Act, which grants the FTC authority to enforce Section 7.[23]

Section 11 confers authority to enforce Section 7 against "the persons . . . subject thereto." 15 U.S.C. § 21. Thus, the plain language of the statute requires that an organization be deemed within the scope of Sec-

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[23] Letter from Donald S. Clark, Secretary, FTC, to Thomas Campbell, Esq., In re Adventist Health Sys./West, No. 881-0122 (Mar. 15, 1989).

tion 7 before Section 11 applies. Yet Section 7 plainly is limited to asset acquisitions by entities "subject to the jurisdiction of the [FTC]." To hold that the phrase "subject to the jurisdiction of the FTC" contained in Section 7 must be defined in reference to Section 11, which in turn refers back to Section 7, is to construe the statute as the functional equivalent of a game of perpetual intellectual ping-pong, with no demonstrable exit point. Indeed, one of the FTC's own hearing examiners has recognized the difficulty of the argument.

> [The FTC] point[s] out that since Section 11 confers authority on the FTC to enforce compliance with Section 7 by "the persons . . . subject thereto," one must look to Section 7 to determine who those persons are, and Section 7 states that those persons are ones "who are subject to the jurisdiction" of the FTC. [Defendants] argue, and I agree, that it is not reasonable to refer . . . to Section 11 to determine who those persons are. It seems to me more reasonable to conclude that the words "subject to the jurisdiction of "[sic] in Section 7 require reference to Section 5 of the FTC Act.

Order Ruling on Respondent's Motion to Dismiss, *In re Adventist Health Sys./West*, No. 9234 (F.T.C. Feb. 8, 1989) (Lewis F. Parker, A.L.J.)

The illogic of the circuit court's view is also evidenced by the fact that prior to 1950, Section 7 of the Clayton Act did not cover not-for-profit charitable entities. It was concerned only with stock transactions, as the circuit court concedes. Pet. App. B at b10-b14. Prior to 1950, therefore, Congress clearly did not intend Section 11 to provide the FTC with enforcement authority over not-for-profit charitable entities. Indeed, with regard to Section 7 as it then existed, such enforcement authority would have been meaningless. Significantly, when Congress expanded the scope of Section 7 in 1950, it did *not* expand the scope of Section 11 in any way which could be read to have expanded the FTC's enforcement authority. Rather, it merely made the remedies of Section 11 co-

extensive with the proscriptions of Section 7.[24] The addition of the limiting language "subject to the jurisdiction of the FTC," which was included in the amendment to Section 7 regarding acquisitions of assets, is hardly consistent with an intent to expand the FTC's jurisdiction over not-for-profit entities. Indeed, the circuit court's interpretation of the amendment renders the limiting language of Section 7's asset-acquisition provision ("subject to the jurisdiction of the Federal Trade Commission") surplusage, and defeats the logical and congressionally-expressed intent to harmonize the asset acquisition and stock acquisition provisions of Section 7. In contrast, interpreting the language as referring to the FTC Act would conform the treatment of asset acquisitions to the treatment previously accorded stock transactions. Neither would apply to not-for-profits.

That Section 11 confers no independent authority is further illuminated by the fact that the Federal Trade Commission Act, 15 U.S.C. §§ 41 *et seq.*, is the fundamental charter of the FTC.[25] All of the FTC's investigatory powers (and, indeed, its legal basis for existence) are contained within that Act. As stated by the administrative law judge in *Adventist Health System/West*, it is not reasonable to assume that Congress' reference to the jurisdiction of the FTC meant anything other than jurisdiction under the FTC's fundamental charter—i.e., the FTC Act. Thus, this Court, in *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963), found the limits of the FTC's jurisdiction for purposes of Section 7 to be defined by Section 5 of the FTC Act, 15 U.S.C.

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[24] *See* S. Rep. No. 1775, 81st Cong., 2d Sess. 9-11 (1950) (the Senate bill was the version adopted by Congress). The Senate report's description of the amendments to Section 11 is devoid of reference to the FTC's jurisdiction. *Id.* at 2-3. *See also* H.R. Rep. No. 1191, 81st Cong., 1st Sess. 5-6 (1949).

[25] The Commission's charter is delimited by Section 4 of that Act, 15 U.S.C. § 44, which defines, inter alia, the "persons" over whom the Commission has jurisdiction. Such persons do not include entities not operated for their own profit or the profit of their members.

§ 45, not Section 11 of the Clayton Act. 374 U.S. at 336. The circuit court's analysis completely disregards this point, and, indeed, fails to even discuss it.[26] Mergers of not-for-profit hospitals must be judged under Section 1 of the Sherman Act, 15 U.S.C. § 1, not under Section 7 of the Clayton Act.

III. THE STANDARD OF LIABILITY UNDER SECTION 1 OF THE SHERMAN ACT IS LESS RESTRICTIVE THAN THE STANDARD OF LIABILITY FOR SECTION 7 OF THE CLAYTON ACT

The circuit court also held that even if Section 7 of the Clayton Act does not apply to not-for-profit mergers, the standard for evaluation should be no different under Section 1 of the Sherman Act. Yet the very existence of Section 7 of the Clayton Act indicates that Congress believed that the Sherman Act imposed a less restrictive standard of liability. Prior to the initial enactment of the Clayton Act in 1914, Congress engaged in a comprehensive analysis of the limitations of the Sherman Act. Again, begining in 1939, Congress undertook an 11-year debate which resulted in the 1950 Amendments to Section 7. Therefore, unless Congress is to be deemed to have embarked in two lengthy episodes of legislative wheel-spinning, the standards of liability under the two acts must be different.

In this regard, the express language of Section 7 of the Clayton Act differs substantially from the language of Section 1 of the Sherman Act. Section 7 speaks of acquisitions and mergers the results of which "may be substantially to lessen competition," 15 U.S.C. § 18, but Section 1 speaks to contracts "in restraint of trade." 15 U.S.C. § 1. The legislative history of Section 7 makes clear that the Clayton Act's intent is to address potential

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[26] Unlike the district court, the circuit court apparently conceded the government's other arguments regarding the applicability of Section 7 are without merit. For a general discussion of the merits of these arguments see generally, Kopit & McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J. Health Pol., Pol'y & L. 635 (1988).

restraints in their "incipiency," before they ripen into conduct which could be prohibited by the Sherman Act. *See Brown Shoe Co. v. United States*, 370 U.S. 294, 318 n.32 (1962). In contrast, the Sherman Act requires anti-competitive conduct creating an actual restraint of trade.[27]

As this Court has repeatedly and consistently stated:

> [A] Clayton Act proceeding require[s] proof only of a potential anti-competitive effect while the Sherman Act carries the more onerous burden of proof of an actual restraint.

Minnesota Mining & Mfg. Co. v. New Jersey Wood Finishing Co., 381 U.S. 311, 323 (1965).[28] There can be no such restraint without conduct that is anti-competitive in its purpose and/or effect.

The Sherman Act requirement of anti-competitive conduct is perhaps most apparent in cases arising under Section 2 of the Sherman Act, 15 U.S.C. § 2. In such cases, it is not the mere possession of economic power that is condemned, rather a violation requires the exercise (or attempted exercise) of such power through predatory or exclusionary conduct. *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 595, 598-99 (1985). *See also Standard Oil Co. v. United States*, 221

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[27] The district court, relying exclusively on Section 7, stated accordingly: "proof of actual anti-competitive practices is not required; rather, evidence that these practices are likely to occur in the future is all that is necessary." Pet. App. A at a139.

[28] Similarly, *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 170 (1964) ("the mandate of the Congress [with regard to Section 7] is in terms of the probability of a lessening of substantial competition, not in terms of a tangible present restraint"); *Philadelphia Nat'l Bank*, 374 U.S. at 355 ("[Not] every violation of Section 7, as amended, would necessarily be a violation of the Sherman Act."); *Brown Shoe Co.*, 370 U.S. at 318 ("Congress rejected, as inappropriate to the problem it sought to remedy, the application to Section 7 cases of the standards for judging the legality of business combinations adopted by the courts in dealing with cases arising under the Sherman Act.").

U.S. 1, 75-76 (1911) (defining the concern of Section 2 as the "intent and purpose to maintain the dominancy . . ., not as a result of normal methods of industrial development, but by new means . . . with the purpose of excluding others from the trade").[29]

The requirement of anti-competitive conduct is no less present under Section 1. *Standard Oil*, 221 U.S. at 61. *United States v. Griffith*, 334 U.S. 100, 106-07 (1948), *overruled on other grounds by Copperweld Corp. v. Independence Tube Co.*, 467 U.S. 752 (1984). Conduct that is plainly anti-competitive—i.e., conduct involving so-called "naked restraints"—may be readily condemned without elaborate analysis of market consequences, but conduct that has the potential to enhance economic efficiency is condemned only upon a demonstration of *actual* anti-competitive effect. *NCAA v. Board of Regents*, 468 U.S. 85, 103 (1984); *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1 (1979); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986).

In some cases, the existence of the anti-competitive conduct necessary to establish a violation of Section 1 is clear from the nature of the agreement itself. *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49-50 (1977).[30] Other agreements, while not per se illegal, may be so plainly anti-competitive in their effect that they also can be condemned without elaborate inquiry into actual market consequences. *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 690-92 (1978); *Indiana Fed'n of Dentists.* However, in other

[29] *See also United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966); *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 626 (1953); *United States v. Griffith*, 334 U.S. 100 (1948), *overruled on other grounds by Copperweld Corp. v. Independence Tube Co.*, 467 U.S. 752 (1984); *Fishman v. Estate of Wirtz*, 807 F.2d 520 (7th Cir. 1986); *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255 (7th Cir. 1981), *cert. denied*, 455 U.S. 921 (1982).

[30] Thus, certain manifestly anti-competitive agreements, such as those to fix prices, or divide markets, are per se illegal. 433 U.S. at 49-50. *See also Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 344 n.15 (1982).

cases, the existence of anti-competitive conduct cannot be inferred from the mere existence of an agreement. *See Business Elecs. Corp. v. Sharp Elecs. Corp.*, 485 U.S. 717, 734-35 (1988) (refusal to condemn agreement to terminate competing distributor without examination of market consequences). Such cases require an inquiry into the actual competitive consequences of an alleged restraint. *See NCAA*, 468 U.S. at 103-04.

Mergers typically are not naked restraints. They "hold the promise of increasing a firm's efficiency and enabling it to compete more effectively." *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 768 (1984). *See also Broadcast Music*, 441 U.S. at 23. Unless it can be established that the agreements result in adverse economic consequences to consumers, the anti-competitive conduct necessary to establish a Section 1 violation may not merely be inferred.

Of course, after consummation of a merger, evidence of predatory or supra-competitive pricing or output restrictions through collusion, or otherwise, would satisfy the requirement of anti-competitive conduct necessary to establish a violation under the Sherman Act. *See Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104, 123 (1986) (Stevens, J. dissenting). On the other hand, where a merger has not been consummated, anti-competitive conduct must be established differently. Plainly, evidence of an anti-competitive purpose or motive—e.g., a motive to drive up prices—would satisfy the requirement by transforming an otherwise ambiguous arrangement into one that is anti-competitive. Similarly, evidence of predatory pricing, or other predatory or exclusionary conduct could furnish the requisite nexus between an economically ambiguous agreement and anti-competitive effect. On the other hand, under Section 1 of the Sherman Act, anti-competitive conduct may not merely be inferred from a merger agreement alone, nor from the increased market shares implicated by the agreement. In this regard, the circuit court's analysis is incorrect.

Battle Over a Machine

One early battle was over a $2 million magnetic resonance imaging machine, the state of the art in diagnostic technology. At first, the hospitals planned to acquire one jointly. But when a group of doctors allied with Borgess (and unaffected by certificate-of-need requirements) bought their own MRI, Borgess acquired a half interest in the doctors' machine instead.

Despite agreements to assure Bronson doctors access to the MRI, "it's turned out that we've been at a disadvantage," says Patric E. Ludwig, Bronson's chief executive officer. Now Bronson intends to acquire its own MRI, a mobile version that can be hauled from hospital to hospital. But the Borgess physicians recently won approval for a mobile unit of their own.

Bronson added open-heart surgery to its fledgling cardiology service in 1987. That nettled Borgess, which has done 7,000 open-heart operations.

Last-Minute Transfer

State health officials ordered Bronson to shut down the service, on the ground that it lacked a permit. Bronson says Borgess provoked the action, something Borgess denies. In any event, Bronson says the order forced one patient, on the eve of his scheduled surgery, to be transferred—to Borgess—for the operation.

Then the state decided it lacked authority to stop Bronson from doing open-heart surgery and permitted the procedures to resume. But Borgess challenged that decision with a pending lawsuit.

"You have a hard time convincing me that you need two heart programs in this town," says R. Timothy Stack, president of Borgess.

"They wanted to maintain a monopoly on that service," replies Mr. Ludwig.

Businesses Gets Involved

Finally, local businesses just couldn't take it anymore —and not only because of increased costs resulting from duplicated services. Because reimbursements from Medicaid and Medicare don't keep pace with costs, both Borgess and Bronson (as well as hospitals around the country) shift a portion of those costs to their paying customers, effectively charging them extra.

Upjohn and other leading companies, many of which have executives on the boards of both hospitals, began demanding some sort of cooperation. In mid-1987, the chief executives of the two hospitals began merger talks. That led to the formation of First Health Development Corp., a company comprising board members and doctors from both institutions.

"The joke in town is that they took the guns off the helicopters during merger negotiations," says Kevin Fickenscher, an assistant dean at Michigan State.

First Health's plan wasn't to eliminate competition but to redefine it so the combined hospital would compete with other hospitals in the region. In October 1988, after over a year of courtship, Bronson and Borgess announced intentions to consolidate.

Almost immediately, the romance turned rocky. In December, Bronson won its fight to resume open-heart surgery and refused to delay the service until negotiations were completed. In January, First Health decided to name a chief executive. The candidates: Borgess's Mr. Stack and Bronson's Mr. Ludwig. The result: a 4-4 vote, deadlocked along loyalty lines. First Health decided to leave the decision up to the board of the combined hospital.

Canon Law

Then came the religious issues. Bronson's Methodist affiliation is little more than a formality, but at Borgess, each day begins with a prayer over the hospital intercom.

CONCLUSION

The issues involving the proper standards for evaluating mergers of not-for-profit hospitals are too important to ignore. The Court should grant a writ of certiorari in order to provide authoritative guidance for distinguishing between those mergers and consolidation of not-for-profit hospitals which are pro-competitive and those that are not.

Respectfully submitted,

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APPENDICES

APPENDICES

APPENDIX A

[Health Care Investment Analysts, Inc., *Competitive Hospital Markets: Differences in Costs and Charges* (1990)]

COMPETITIVE HOSPITAL MARKETS:

DIFFERENCES IN COSTS AND CHARGES

An internal research study conducted by

HEALTH CARE INVESTMENT ANALYSTS, INC.
207 East Redwood Street, Suite 400
Baltimore, Maryland 21202

April 9, 1990

Conclusions and data contained herein have been obtained from sources considered accurate and reliable. Health Care Investment Analysts, Inc. makes no guarantee as to such accuracy and disclaims any legal responsibility.

INTRODUCTION

In order to ascertain the degree to which differences in per-unit costs and charges may exist in hospitals located in different types of markets, Health Care Investment Analysts, Inc. (HCIA) conducted an internal research study that focused on this issue. Historically, HCIA has prepared internal research studies from time to time, and the firm intends to produce three to four such studies each year.

DATA AND METHODS

Data for this analysis were extracted from HCIA's hospital data base, which consists of data for approximately 6,000 community, children's, psychiatric, and rehabilitation hospitals throughout the U.S. The HCIA hospital data base includes more than 400 data elements per facility and currently spans the 1984 to 1988 period in its entirety, while including most data for 1989 except for hospitals whose fiscal years end in December. The HCIA hospital data base is constructed from annual filings of hospitals' Medicare cost reports. Used by many experts as a source of hospital financial and operating data, the cost report has proven to be a reliable document and the basis for many published research articles.

Every community hospital in the U.S. was classified as being located in one of three different market types: one-hospital markets, markets with two or three hospitals, and markets with four or more hospitals. Most hospital industry experts would agree that the above definitions of hospital market types are acceptable. Markets were determined on the basis of geographic proximity. Hospitals in rural areas were considered to be in the same market if they were within 30 miles of each other. In suburban and urban areas, the distance was reduced to five miles.

Hospital size was controlled for by restricting the sample to those hospitals with 100 to 400 beds. Hospitals in

this size category are most likely to have similar cost and charge structures. Extremely small hospitals (those with less than 100 beds) and extremely large hospitals (those with more than 400 beds) were excluded from the analysis since their cost structures are much different from the archetypical community hospital that has between 100 and 400 beds. As a group, hospitals between 100 and 400 beds comprise approximately 35 percent of the universe of community hospitals.

The median **Costs per case** and the median **Charges per case** were calculated for the three groups of hospitals. Costs per case were calculated as expense per adjusted admission and charges per case were calculated as gross revenue per adjusted admission. Admissions were *adjusted* using the Adjusted Factor described below.

Expense per Adjusted Admission. The total expenses of a hospital divided by the number of adjusted admissions to the hospital. Expense per adjusted admission is the best measure of the average *inpatient cost* per unit (per case) in a hospital.

Gross Patient Revenue per Adjusted Admission. Total charges for a hospital's patient care services divided by the number of adjusted admissions to a hospital. Gross patient revenue per adjusted admissions is one measure of the average inpatient price per unit (per case) in a hospital. It reflects the price per admission to charge-based payors (typically commercial insurance companies, self-pay patients, and, in some states, Blue Cross).

Adjustment Factor. Calculated as the ratio of gross patient to inpatient revenue, excluding subprovider, ICF, SNF, and other *non-inpatient* revenue, the adjustment factor provides an easy method of inflating inpatient units of volume (namely admissions and patient days) to approximate an equivalent amount of non-inpatient volume. Without the adjustment factor, a *total facility* data element (*e.g.*, gross patient revenue) which includes

outpatient revenue and SNF revenue among other things, would be divided by a strictly *inpatient* unit of volume (*e.g.*, admissions). The adjustment factor usually ranges in value between 1.10 and 1.60 depending on the hospital.

Two standard adjustments were then made to these measures to allow for better comparisons.

Complexity of Case Mix. If a hospital treats a difficult mix of patients when compared with the norm, it is likely to have both higher average costs and higher average charges per case since more difficult cases justify the use of more resources. For example, a hospital that does a large amount of open-heart surgeries will be a more costly hospital than a hospital that specializes in simpler cases. We used a U.S. government index (each hospital's Medicare Case Mix Index) to standardize for these differences in patient complexity levels.

Location. One of the most obvious reasons for one hospital to be more costly than another would be the fact that it may be located in a metropolitan area and be forced to pay higher wages for similar employees when compared with a hospital located in a rural area where wage levels may be as much as 25 percent lower. In deriving the figures for this study, we standardized all data for differences in urban and rural wage levels using a U.S. government index that was specifically designed for that purpose, the Health Care Financing Administration's Area Wage Index. (In a typical hospital, wages and benefits account for approximately 55 percent of operating expenses.)

RESULTS

The results from the study are presented below in Figure 1. Hospitals in the most competitive markets (four or more hospital markets) had **Costs per case** that were 17 percent higher than hospitals without competition (one-hospital markets) and were 11 percent higher than hospitals that faced moderate competition (two-

and-three hospital markets). **Charges per case** were 24 percent higher in the most competitive markets (four or more hospitals) when compared with the least competitive (one-hospital) and 14 percent higher when compared with hospitals located in moderately competitive markets (two-and-three hospital markets).

Figure 1. Median Values for Costs and Charges per Case

	1988	1987	1986	1985	1984
COSTS PER CASE ($)					
One-Hospital Markets	2,659	2,532	2,383	2,311	2,171
Two-Three Hospital Markets	2,804	2,706	2,552	2,400	2,290
Four+ Hospital Markets	3,116	3,001	2,812	2,648	2,595
CHARGES PER CASE ($)					
One-Hospital Markets	3,488	3,289	2,916	2,743	2,602
Two-Three Hospital Markets	3,798	3,473	3,201	2,973	2,856
Four+ Hospital Markets	4,337	4,009	3,626	3,365	3,283

CONCLUSION

Hospitals in the most competitive markets clearly had costs and charges that were higher than hospitals located in less competitive markets. While this study did not use rigorous statistical techniques, the differences in costs and charges were large enough to infer that they would still exist if such techniques were employed.

The results add further to the body of existing literature that indicates the dysfunctional nature of the economics of the hospital industry. For example, classical economic theory would suggest that hospitals in the most competitive markets would have the lowest prices and, in order to remain profitable, the lowest costs. Perhaps the market-clearing price that currently exists in competitive markets is too high and hospitals in those markets still have substantial cost-reduction and efficiency gains that have yet to be realized.

For further information on HCIA's ongoing research agenda, please call Mr. Daniel F. Heneghan, Vice President, at telephone (301) 576-9600.

APPENDIX B

[Winslow, *Competitive Anomaly: Consumers Pay More in 2-Hospital Towns*, Wall St. J., June 6, 1990, at 1, col. 1]

Rival Operations
Competitive Anomaly:
Consumers Pay More
In 2-Hospital Towns

In Kalamazoo, a Nasty War
Means Duplicated Efforts;
Big Business Gets Fed Up

A Dogfight Over Helicopters

By RON WINSLOW
Staff Reporter of THE WALL STREET JOURNAL

KALAMAZOO, Mich.—When the two archrival hospitals here found out that both planned to launch helicopter ambulance services, they flew into action. Borgess Medical Center quickly found a copter, called photographers and was first to get pictures in the local paper.

But Bronson Methodist Hospital struck back, getting its chopper into the air first and proudly proclaiming a nurse aboard every flight.

Borgess retaliated three months later, boasting a *doctor* on every trip. Within a year, each hospital had upgraded to twin-engine choppers—making the announcement the same week. "There are only 90 helicopter ambulances in

the whole counry," an exasperated executive of Upjohn Co., the city's largest employer, said at the time, "and two of them are here."

Not to mention two heart programs, two maternity wards, two state-of-the-art emergency rooms, and two radiology services. There were even two billboard campaigns. Robert Fabi, a respected neurologist who has practiced here for more than 20 years, describes the situation in verse: "Given the history of Kalamazoo, if there is one, there will be two."

* * * *

National Microcosm

In most businesses, competition cuts prices. But hospital bills in Kalamazoo, a metropolitan area of 200,000 between Detroit and Chicago, are the second highest in Michigan and among the highest in the nation. In general, hospital costs in two-hospital towns like Kalamazoo are 30% higher than in one-hospital communities, according to a survey by Booz-Allen & Hamilton, Chicago consultants. "Kalamazoo is a microcosm of the national environment," says Gary Alquist, a Booz-Allen vice president and health-care specialist.

Charges per admission in 1988 averaged $6,112, 55% higher than in nearby Grand Rapids and 34% above the national average for metropolitan areas. Health costs at James River Corp.'s Kalamazoo paper packing operations rank in the top three of the company's 15 similar units nationwide. When it comes to further expansion, health costs put the area "at a competitive disadvantage versus some of the other communities we do business in," says Norman Ryan, a James River executive.

The costs are a threat to both corporate profits and the region's economic growth. Total medical costs here rose nearly 15% last year at Upjohn, a pharmaceutical concern, and 20% at both Stryker Corp., a medical equip-

ment company, and Fabri-Kal, a plastic products maker. First of America Corp., a bank holding company, budgeted a 45% increase in costs this year from 1989. "We have good medical care," says Theodore Cooper, chairman, president and chief executive of Upjohn. "We need it to be priced right."

As a result, Upjohn and other major businesses here have tried hard to get the hospitals to cooperate. But

[Photo Omitted]

Borgess's Helicopter

nearly all the efforts have failed. Last fall, the most ambitious—a two-year effort to merge the hospitals, one Catholic and one Methodist—collapsed over the issue of abortion.

Bronson and Borgess haven't gotten along since the turn of the century, when a group of doctors left Borgess, which had been founded by the Sisters of St. Joseph, to start their own hospital. Each hospital, of course, has its own version of that.

Borgess says the doctors were kicked out in a philosophical tiff with a nun about, among other things, religious influence over medical care. Bronson says the physicians left after the nuns refused to shorten their habits, which the doctors believed swept up germ-laden dust as they swished along the floor.

Over the next several decades, the hospitals divided up patients along religious and ethnic lines. "If your name was Kelly, you went to Borgess," says Dan Ryan, retired editor of the Kalamazoo Gazette, himself a Borgess baby.

In the 1950s, Bronson was the first to add a wing and lease space to physicians, drawing first blood in the war for supremacy. "You began having guys who were Bronson doctors and Borgess doctors," says Mr. Ryan.

In the 1960s and 1970s, Borgess was particularly successful at recruiting physicians highly trained in such emerging areas as heart surgery and neurology. With the help of an infusion of Medicare and other federal health funds, both institutions established centers for a variety of medical specialties.

Bronson has a burn unit, a neonatal intensive care ward and strong pediatric and women's services. Borgess stresses cardiology and neurosurgery and does kidney transplants.

Bronson is a sprawling 442-bed facility crammed into a downtown city block. Borgess is a 458-bed hospital on 40 acres just two miles away. Both reported revenues of about $140 million in 1988; both offer comprehensive services for the treatment of critically ill patients.

Between 1970 and 1980, the number of physicians in Kalamazoo doubled, intensifying the use of medical resources—and competition. Doctors, with power to refer and admit patients, are catalysts in hospital battles. When Bronson refused to purchase expensive surgical tables for some orthopedic surgeons a few years ago, "they picked up their scalpels and went across town," says Russell Kneen, former chief executive at Bronson.

Regulation plays a crucial role as well. In the early 1980s, the U.S. instituted a program to control Medicare and Medicaid costs by reducing hospital admissions and shortening stays. Meantime, Michigan was one of many states that enacted so-called certificate-of-need laws that require hospitals to prove the need for expensive new technology and services.

The result: Between 1984 and 1988, the Kalamazoo in-patient market shrank by 10%. But certificate-of-need rules meant that being second with new technology necessary to compete for the dwindling supply of patients could mean not getting the technology at all. Competition, already fierce, turned nasty.

While neither side retained counsel who specialized in mergers and acquisitions for the talks, Borgess hired a canon lawyer to protect its religious interests.

Borgess insisted Bronson agree to bar abortion. Bronson said abortions had to be available, even though the hospital had performed just four in 1988. Finally, Bronson agreed to do no abortions except in cases of anencephaly, in which the brain fails to develop, or other rare instances when the prognosis for the fetus is hopeless.

That wasn't good enough. Last October, talks collapsed. And this spring, a new front in the war opened: laser surgery.

Borgess announced in March it intended to triple its annual volume of 500 laser procedures. In April, Bronson, which says it already does 1,500 a year, trumped the plans by performing the region's first laser gallbladder surgery—and trumpeting the feat in newspaper ads.

"They're trying a pre-emptive thing to minimize the impact of our program," charges J. Patrick Dyson, a Borgess senior vice president. "One of the surgeons flew in from out of town," he adds. "It's what we call itinerant surgery." Bronson concedes the out-of-town surgeon trained the Bronson doctors in the procedure, but he merely watched "to make sure everything went fine," says James B. Falahee Jr., Bronson's general counsel.

In this environment, businesses are looking at other ways to keep costs down. Upjohn and other companies are considering negotiating discount rates in return for a guaranteed flow of patients. "We've never tried to bid one against the other," says Upjohn's Dr. Cooper. "But we do have other responsibilities," including assuring "a fair return to shareholders."

Some Cooperation

The pressure is having some effect. Since 1985, Bronson has trimmed staff by 9%. It didn't raise rates last year, and last month announced a 5% across-the-board price cut. It pledges to cut the difference between Bronson and Grand Rapids hospitals by half this year. Borgess has reduced its work force as well and plans package rates for cardiology and other specialties.

One important cooperative effort is making headway. In February, the hospitals announced plans to build a joint $10 million outpatient cancer treatment center downtown. Among other things, it would mean the purchase of just one million-dollar linear accelerator (used in radiation treatment) instead of two.

A group of local executives called the CEO Council is prodding the hospitals to consolidate other services. One prime candidate: the helicopters. The hospitals say each chopper makes more than 600 flights a year, enough to justify two. They often back each other up, and it isn't unusual to see the Bronson helicopter deliver a patient to Borgess and vice versa.

Operating both units costs a total of $5 million a year, says Dave Kovacs, medical director of Borgess Inflight Medical Services, and combining their operations would save at least $1 million, even while keeping both choppers running.

But the helicopters are objects of intense pride. "We feel ours has been successful because we are the major trauma center," Bronson's Mr. Ludwig says. It plays an important role in Bronson's emergency service, which generates 30% of patient admissions, he adds.

Borgess, on the other hand, even distributes postcards and calendars with pictures of its chopper in flight. And Borgess proudly says that its was the first to rack up 3,000 trips. Told that Bronson considers its own service the leader, Mr. Stack shrugs and says: "It's a popular misconception on their part."

APPENDIX C

[Transcript Excerpt from Testimony of David Michael Eisenstadt, Ph.D.]

[14-3] DAVID MICHAEL EISENSTADT,
DEFENDANTS' WITNESS, SWORN

DIRECT EXAMINATION

BY MR. KOPIT:

Q Could you please state your full name for the record?

A David Michael Eisenstadt.

Q Spell your last name, please.

A E-i-s-e-n-s-t-a-d-t.

Q And it's Dr. Eisenstadt, isn't it?

A That's correct.

Q Ph.D. Economist?

A Yes.

Q Dr. Eisenstadt, by whom are you employed?

A ICF Consulting Associates.

Q What type of work does ICF Consulting Associates do?

* * * *

A The group I am with specializes in industrial organization and antitrust economics.

* * * *

[14-4] Q Could you describe, based on that *vitae*, briefly, Dr. Eisenstadt, what your educational background is?

A I have a bachelor's in economics from the University of Maryland and a master's and Ph.D. in Economics from the University of Illinois.

Q And what areas of economics do you consider yourself to be expert in?

A My areas of specialization are industrial organization and health care and antitrust economics.

* * * *

[14-5] Q What did you do when you left the University of Missouri? What was your next job?

A I went to work for the United States Department of Justice Antitrust Division.

Q And how long were you with the Justice Department?

A Approximately five years.

Q While you were at the Justice Department, did you receive any promotions, early promotions or commendations or both?

A Yes. I received awards for outstanding performance, special achievement, and I received several early promotions.

Q What group were you in in the Department of Justice Antitrust Division?

A At the time the group was called the Economic Policy Office. The name has changed; it is now called the Economic Analysis Group.

Q And you say you were there five years, roughly?

A Approximately.

* * * *

[14-8] Q Okay. Can you describe the experience of your colleagues at ICF?

A The officers in my group who are based in Washington each have between five and ten years' experience at the United States Department Antitrust Division (sic).

Q All of them?

A Excuse me, that would be United States Department of Justice Antitrust Division.

Q All of them?

A Yes, each of them.

Q And is it customary for you to consult with these colleagues during a client engagement?

A I would say it's not only customary, it's expected.

Q And in total, how long have you worked in the field of economics?

A Since graduate school?

Q Yes.

A About ten years.

Q And how much of your work has been in the field of health care economics?

A Approximately 70 percent.

Q And are you a member of the Merger Task Force of the [14-9] American Hospital Association currently?

A Yes, I am.

Q Are you, in fact, the only economist on that task force?

A Yes, to my knowledge.

Q And how much of your work would you say involves, which you mentioned before, industrial organization?

A I would say industrial organization issues pertain to in excess of 90 percent of the work I do.

Q And could you enlighten both the jury and the Court and me as to what exactly is industrial organization?

A Industrial organization is a subdiscipline in economics and it is the study of market structure, market conduct and market performance.

* * * *

MR. KOPIT: Your Honor, at this time I'd like to offer Dr. Eisenstadt as an expert in health care antitrust economics and industrial organization.

THE COURT: All right.

BY MR. KOPIT (Resuming):

Q When were you retained as a consultant to defendant hospitals in this case?

A In the fall of 1987.

* * * *

[14-10] Q Now, you've been working with—well, when did you start your work in depth with these hospital defendants?

A February, 1988.

Q And that's ten months or so, more than ten months? Is that right?

A A little over ten months ago, assuming I started right at February 1.

Q And how much of your time in hours would you estimate has been spent analyzing the issues of this case during those months?

A How many hours have I worked?

Q Yes.

[14-11] A I would guess in the neighborhood of 2,000 hours.

* * * *

[14-15] Q Did you suggest a specific nature of the work that you thought should be done or that you wanted to do?

A Yes, I did. I proposed a study which would examine the effects, if you will, of recent hospital mergers in other areas to determine whether such mergers resulted in price increases.

Q Now, you were talking previously about work you had done in conjunction with two other non-profit mergers, hospital merger situations; one in Danville, Illinois, I believe, and the other in, was it Reading, Pennsylvania?

A That is correct.

Q Had you done previous studies relating to what you were doing in Danville, Illinois?

A Yes. I had prepared a study which was submitted to the United States Department of Justice pursuant to that particular investigation in Danville.

Q And what was the nature of the study that you did for Danville?

A The study was, it was a statistical study which examined [14-16] whether hospital prices were higher in areas with fewer hospitals.

Q What was the geographic area that the study looked at?

A I was examining areas which would have been areas that had very new hospitals in ten Midwestern states.

Q And what were your findings in the Danville study?

A I found no evidence that prices were higher in areas with fewer hospitals.

* * * *

[14-17] Q Now, in addition to Danville, I believe you mentioned Reading, Pennsylvania. Did you do a study relating to Reading for what you were doing for the Reading hospital?

A Yes. I did another study which was parallel, if you will, to the study that was done for the Danville situation, and I was reviewing and examining statistical evidence to determine whether hospital prices in Pennsylvania were higher in areas with fewer hospitals, and I found no such evidence.

Q And that was submitted to the Federal Trade Commission?

A Yes, it was, in a report.

* * * *

[14-18] Q So, you've previously done two other studies concerning non-profit hospital mergers when you made your recommendation to these defendants; is that correct?

A That is correct.

* * * *

Q Let's focus on the first study you did for these hospitals which you've mentioned before that you proposed to them. Again, how was that different from the studies that you were doing in Pennsylvania or had done in Pennsylvania in Danville, Illinois?

A The study I proposed in this case looked specifically at recent hospital mergers as this case is just about a proposed merger, if you will, or affiliation. I wanted to

determine whether, as a result of such mergers, hospital prices went up in the areas that experienced these consolidations.

* * * *

[14-21] I, let me ask you this. Did you exclude any non-profit hospitals that met your criteria for selection?

A No, not to my knowledge. The basis for determining whether such mergers occurred came from reviewing American Hospital Association data summary sheets, if you will, that the American Hospital Association publishes, which indicate merger activity which occurred each year.

Q And do you have anything in general you want to say about why these criteria for selection that you did use were important to you?

A Again, I wanted to, to the best of my ability, assure that the areas that were under study were comparable to the Roanoke area in terms of the non-profit status of the hospital, in terms of the number of hospitals in the community, et cetera.

Q And what were the conclusions of this merger study that you did for the defendant hospitals?

A I found no evidence of a statistically significant relationship between rates of price increase in these areas which experience mergers and rates of price increase in comparable areas that did not experience mergers.

Q Now, in addition to this study did you then do any other [14-22] statistical research?

A Yes.

Q And when was that?

A In late May or June I proposed another study to the defendant hospitals, and that study, the proposed study would have examined the relationship between hospital prices and the number of hospitals in particular areas in Virginia.

Q And what statistical technique did you use to perform that, if you will, second study?

A Multiple regression analysis.

Q Could you take a look—

A I should also point out that multiple regression analysis was also used to perform the merger study.

* * * *

[14-27] Q Could you explain the difference between the simple regression analysis and multiple regression analysis?

A Multiple regression analysis would account for more than one influence, in this case, on hospital prices. It would account for the fact that there are many influences on hospital prices, of which market concentration might be only one. For instance, hospitals have different wage levels. Wage levels are an indication of hospital costs, and hospital costs would affect hospital prices. Case mix severity would be—

Q Let me just stop you with the wage indices.

A Yes.

Q Wage indices are likely to be scattered randomly or is there likely to be some correlation as to whether the hospital is in a rural area or urban area?

A I would expect wage levels would be lower among hospitals in rural areas. In addition, those hospitals in rural areas tend to be fairly isolated, and they tend to be, there tend to be very few of them, so one would not want to attribute effects of market concentration on prices which are really due to the fact that there are differences in wage levels among hospitals, and that's why one does a multiple regression analysis to isolate out the separate effects of such influence on the particular variable of interest, in this case the Blue Cross payment rate.

[14-28] Q I interrupted you. You were giving us some examples of what those other factors or influences that you consider relevant are.

A Yes, things like differences in wage levels among hospitals, differences in case mix severity, differences in average length of stay, whether the hospital is a teaching

facility. Those types of things would all have an influence, in my opinion, on hospital prices.

Q Let me ask you just one more explanation of one of these influences. You say you look at differences in case mix, did you say?

A Yes.

Q Why would that be important or relevant?

A Well, hospitals that have more severe case mix treat sicker patients, and it's more expensive to treat sicker patients and, therefore, those hospitals would quite naturally have higher prices.

Q Or—

A Or be expected to have higher prices.

Q You call these influences or factors independent variables?

A That is what they're called. It's a term of art.

Q How many of these independent variables did you account for in total?

A Approximately 20.

[14-29] Q What measures of price did you examine in this second study that you did, if you will?

A The second study, looking at the relationship between hospital prices in Virginia and market concentration as measured by the Herfindahl index?

Q Yes.

A I looked at a number of different measures of hospital prices. The Virginia Health Services Cost Review Council publishes data on hospital prices, and I used that information, as well as information on Blue Cross payment rates per day and Blue Cross list prices per day. These would have been the prices that Blue Cross enrollees would have paid had they paid list price, which would be, if you will, an index of what commercial insurers pay, like Aetna, Prudential, et cetera.

Q How many, how many years' data did you examine?

A I examined three years' worth of price data.

* * * *

[14-30] THE COURT: All right

Q And could you describe, basically, what the summary shows?

A Well, quite simply, in none of the studies, in none of the regressions that I've looked at do I find any evidence of a statistical relationship between hospital prices and market concentration.

* * * *

[14-32] Q Now, do you view the results of these studies you did to mean that one should have little confidence in any prediction that hospital prices will go up as a result of the affiliation between Roanoke Memorial or Carilion and Community Hospital?

A Yes, I would say that the results of the studies indicate that there is no statistical evidence, if you will, that there is a significant relationship between the number of hospitals in an area and hospital prices.

Q And why do you think that your data shows no relationship between market concentration and price?

A Well, that's an excellent question.

Q Have you ever heard it before?

A Yes, many times. I think this is a unique industry where the standard presumption about the relationship between price and the number of firms in a market doesn't necessarily apply, and specifically for these results I think there are three [14-33] possible explanations, and they relate to the cornerstone assumptions, if you will, of the Government's case in this matter. The first assumption is that markets are narrowly defined, and those would be either product markets or geographic markets. The second assumption that the Government has made is that there is no difference in behavior between for-profit and non-profit hospitals. I think there are differences in behavior, and I think the report indicates that there are differences in behavior between the two types of hospitals. Those hospitals in Virginia are non-profit. And the third key assumption, if you will, in the Govern-

ment's case is that the Virginia Health Services Cost Review Council is ineffective in regulating hospitals. And these results suggest to me that one or more of those three assumptions is likely to be incorrect.

Q Those are the reasons you give. They could all apply to some extent?

A It is possible. At the present time I can't separate out which—

* * * *